Connecticut State Medical Society

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House Bill 5311 An Act Imposing a Moratorium on Changes to Current Procedural Terminology Codes
Insurance and Real Estate Committee
February 8, 2011

Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, my name is Matthew Katz, Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of the more than 7,000 physician and physician in training members of the CSMS, thank you for the opportunity to provide this testimony to you today on House Bill 5311 An Act Imposing a Moratorium on Changes to Current Procedural Terminology Codes. We appreciate the intent of the legislation and welcome the opportunity to address concerns regarding the potential impact of deviation from established codes.

Current Procedural Terminology (CPT), is the listing of descriptive terms and identifying codes for the reporting of medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services. CPT provides an effective means of reliability communicating among physicians, patients and third parties, such as health insurers and the federal and state government the services and procedures provided by physicians.

CPT descriptive terms and identifying codes serve a wide variety of important functions in the field of medical nomenclature, especially for the administrative management of physician practices, claims processing and in medical care review. The uniform language is also important in the field of medical education and outcomes research, as well as health services and quality research, providing a useful and uniform method to compare, local, regional and national utilization of services and procedures.

CPT is the federally identified national standard as it was designated by the Department of Health and Human Services in 2000 as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA).

Every year there are hundreds and in some cases thousands of coding changes that impact how physicians and other health care professionals document and record the services and procedures they provide. These physicians and other health care professionals must abide by the most current or most recent revision to CPT. CPT code set is published annually for use with an effective date of January 1st. The inclusion of a descriptor and its associated five-digit code number or two digit code number for a modifier (modifying code) in the CPT codebook is based on whether the procedure is consistent with

contemporary medical practice and is performed by practitioners in clinical practice in multiple locations.

CSMS believes that health insurers and other third party payors should adhere to these same CPT codes, guidelines and conventions presented in the CPT book and associated CPT materials. If physicians and other health care professionals have to apply the codes, guidelines and conventions of CPT consistently, so should health insurers and other payors and entities that deal with health insurance claims and medical billing information. It is critical that the same set of CPT codes, descriptions, and guidelines are applied consistently to describe procedures and services performed by physicians and other health care professionals and providers. Requiring practitioners to use or apply one standard and allowing insurers and other payors to apply differing standards creates confusion, may lead to deception and prevents transparency in the health care system.

Therefore, rather than a three year moratorium on changes to CPT codes, CSMS recommends that language be amended to require insurers to comply with any changes to CPT codes immediately.